Makara Journal of Health Research

Volume 30
Issue 1 *April*

Article 4

4-25-2026

Questionnaire for Eudaimonic Well-Being: Psychometric Validation Among Malaysian Youth

Mohd Ahsani A. Malek
School of Applied Psychology, Social Work, and Policy, Universiti Utara Malaysia, Sintok 06010, Malaysia, mohd.ahsani@uum.edu.my

Nurulwahida Saad
Kulliyyah of Allied Health Sciences, International Islamic University Malaysia, Kuantan 25200, Malaysia, nurulwahida@iium.edu.my

Suzana Mohd. Hoesni
Centre for Research in Psychology & Human Well-being, Universiti Kebangsaan Malaysia, Bangi 43600, Malaysia, smh@ukm.edu.my

Muhamad Ariff Ibrahim
Kulliyyah of Allied Health Sciences, International Islamic University Malaysia, Kuantan 25200, Malaysia, ariffib@iium.edu.my

Nurul Shafira Adi
Faculty of Psychology and Social Work, Universiti Malaysia Sabah, Kota Kinabalu 88400, Malaysia, shafira@ums.edu.my

Recommended Citation

A Malek MA, Saad N, Mohd Hoesni S, Ibrahim MA, Adi NS, Mohd Nazori MN. Questionnaire for Eudaimonic Well-Being: Psychometric Validation Among Malaysian Youth. Makara J Health Res. 2026;30(1):25-32.

Questionnaire for Eudaimonic Well-Being: Psychometric Validation Among Malaysian Youth

Authors

Mohd Ahsani A. Malek, Nurulwahida Saad, Suzana Mohd. Hoesni, Muhamad Ariff Ibrahim, Nurul Shafira Adi, and Mohd Nazir Mohd Nazori

Makara J Health Res. 2026;30(1):25–32
doi: 10.7454/msk.v30i1.1969

Makara Journal of Health Research

Questionnaire for Eudaimonic Well-Being: Psychometric Validation Among Malaysian Youth

Mohd Ahsani A. Malek[1], Nurulwahida Saad[2], Suzana Mohd Hoesni[3], Muhamad Ariff Ibrahim[2], Nurul Shafira Adi[4], Mohd Nazir Mohd Nazori[2*]

[1]School of Applied Psychology, Social Work, and Policy, Universiti Utara Malaysia, Sintok 06010, Malaysia
[2]Kulliyyah of Allied Health Sciences, International Islamic University Malaysia, Kuantan 25200, Malaysia
[3]Centre for Research in Psychology & Human Well-being, Universiti Kebangsaan Malaysia, Bangi 43600, Malaysia
[4]Faculty of Psychology and Social Work, Universiti Malaysia Sabah, Kota Kinabalu 88400, Malaysia

Abstract

Background: The rising prevalence of mental illness underscores the need to understand how individuals can live and flourish under such conditions. In Malaysia, research has largely emphasized diagnosis and treatment, with limited focus on positive psychology and few validated instruments. This study aimed to translate and validate the questionnaire for eudaimonic well-being (QEWB) among Malaysian youth.

Methods: The QEWB was translated into Malay using back-to-back translation and administered to undergraduates from four public universities through a cross-sectional survey design. Convenience quota sampling was used, resulting in 229 respondents completing the online form to measure sociodemographic characteristics, eudaimonic well-being, stress, and general well-being. Factor analyses were used to assess construct validity, whereas Pearson's correlation was used to test criterion validity.

Results: A three-factor (17 items) and one-factor (15 items) model were supported. The 3 factors—intensity of self-expression, importance of fulfillment, and attitude toward growth—showed good validity and reliability (α = 0.74 – 0.88). The one-factor model also exhibited strong validity and reliability (α = 0.81). Both models significantly correlate positively with general well-being (r = 0.44 – 0.76, $p < 0.01$) and negatively with stress (r = −0.29 to −0.43, $p < 0.01$).

Conclusions: The Malay QEWB is reliable and facilitates the integration of eudaimonic well-being in Malaysian research and practice.

Keywords: mental health, psychological well-being, psychometric, young adult

INTRODUCTION

Research on mental well-being in Malaysia has received increasing attention from the academic community and health care services, consistent with the increasing incidence of mental illness and its complications. The most recent report from the World Health Organization (WHO) highlighted that 1.095 billion people are living with mental disorders.[1] The World Health Organization report noted that the prevalence of mental disorders showed a remarkable increment among youth and remained consistent in later stages of life. An exponential increase was observed in 2019, possibly due to the COVID-19 pandemic.[2] The Malaysian Youth Mental Health Index (MyMHI'23) reported that the prevalence of suicidal thoughts and attempts has increased from 10 % to 13.1 % in the past five years.[3] Youth are found to be at a higher risk of developing anxiety or depression, which may lead to a deteriorating trend in the population.

***Corresponding author:**
Mohd Nazir Mohd Nazori
Kulliyyah of Allied Health Sciences, International Islamic University Malaysia, Kuantan, Malaysia
E-mail: nazirnazori@iium.edu.my

Theories on mental well-being describe 2 subdimensions: hedonic and eudaimonic. The hedonic subdimension refers to a person's experience of happiness and other positive emotions in a moment.[4] This is often seen as the end goal of life. The eudaimonic subdimension, on the other hand, refers to the process experience that describes the expression of autonomy, mastery, growth, relationships with others, purpose in life, and self-acceptance.[5] These qualities underlie the motivation to develop a good quality of life.[6] Most research in Malaysia has covered specific diagnoses[7] and outcomes for poor mental health, such as suicidal ideation, suicidal attempt,[8] and QoL.[9,10] However, knowledge and practical gaps remain.

Previous research has skewed our understanding of mental well-being toward the aspect of the disease rather than the functional aspect of the situation, as espoused by the positive psychology perspective. Our understanding of the predictors of disease development and its progression and the effectiveness of pharmacological or psychotherapy interventions has improved.[11,12] However, the body of knowledge in Malaysia seems disproportionately lacking in the understanding of productive living with the disease. This knowledge gap leads to a practical gap in understanding and designing

ways to improve mental well-being across the spectrum, from those without and with mental illness. As defined and visioned by the World Health Organization, knowledge should be developed to enable practice that empowers individuals to be "able to develop" ability and skills to function effectively and "contribute" to the community despite the presence of mental illness. Measuring the treatment outcome using symptoms or their complications is also inconsiderate of the cyclical nature toward recovery. Lived experience individuals experienced remission and relapse throughout their functioning life.[13] In contrast, positive psychology introduces key concepts that have shown long-term recovery benefits. For example, a longitudinal study among individuals with mental health disorders showed better reduction in psychological distress and improved recovery through developing an affirmed identity and valued living practices.[14]

The lack of focus on mental well-being in local research may have been contributed by the lack of validated instruments that measure mental health from the perspective of positive psychology. The WHO-5 and several other quality of life questionnaires are available and validated locally. Despite its conciseness in measuring mental well-being, the WHO-5 operationalizes the construct in a generic form rather than encompassing the hedonic and eudaimonic subdimensions of mental well-being. A detailed understanding of the contribution of specific predictors to mental well-being would not be possible. Other QoL questionnaires were more directed toward the hedonic definition of mental well-being.[15] Therefore, this study aims to translate and validate the QEWB among youth attending public universities throughout Malaysia. The availability of a validated questionnaire focused on the eudemonic subdimensions of mental well-being will enable future researchers to explore the construct and integrate positive psychology insights into their interventions.

METHODS

This study was approved by the IIUM Research Ethics Committee [IREC 2024-266]. The online survey platform provided the information sheet and consent form. The contact details of the principal researcher were provided, should any respondents need clarification. Each respondent was given a copy of their responses.

The English QEWB questionnaire was translated into Malay using a back-to-back translation process. The first Malay draft was independently translated by a linguist and a subject matter expert fluent in both English and Malay. The resulting Malay drafts were compared and discussed to produce a unified Malay draft of the QEWB. This unified Malay draft was then translated back into English by another linguist fluent in both languages who was blinded to the details of the original questionnaire. The translation steps followed the cross-cultural translation guide for the health questionnaire by Rahman *et al*.[16] All translated drafts were compared and discussed to produce the final Malay draft of the QEWB.

Sample size calculation was done using a ratio of ten respondents per item for confirmatory factor analysis[17] yielding a minimum sample size of 210 respondents. After accounting for 20 % nonresponse rate, the final sample size was 252 respondents. The questionnaire was self-administered to youth attending 4 public universities in Malaysia using an online survey platform. The universities were selected by simple random sampling to identify one university to represent the North, East, Central, and Borneo regions. Respondents at each university were selected using convenience quota sampling, with each university having 70 respondents. This study aimed to establish the validity and reliability of the QEWB questionnaire and identify potential regional differences. Given the limited scope and available resources, convenience quota sampling was used. Youth that meet the following criteria were included in the research: (a) aged 19–30 years and (b) enrolled in full or part-time study. No exclusion criteria were established. Eudaimonic well-being advocates a life of flourishing despite having an illness. Hence, respondents with a mental health diagnosis were not excluded from this study.

The questionnaire consisted of sociodemographic details, the final Malay draft of the QEWB, and instruments to measure stress and general well-being. The original QEWB comprises 21 items measuring one dimension. The response option used a five-point interval scale from "totally disagree" to "totally agree." The original instrument obtained good evidence of content, construct, convergent, and divergent validities with a 0.85 index on Cronbach's alpha.[18] The content validity was established through a review by several subject matter experts and psychologists. Construct validity was established with a single-factor structure using CFA. Convergent and divergent validity were established against measures of the social well-being questionnaire, psychological well-being questionnaire, and identity moratorium. Stress was measured using the stress subdimension of the Depression, Anxiety, and Stress Scale 21 (DASS-21), consisting of seven items measured on a five-point interval scale. The questionnaire showed good construct validity and a Cronbach's alpha of 0.79 among the local population.[19] The WHO-5 questionnaire was used to measure general well-being, consisting of 5 items measured on a six-point interval scale. The questionnaire showed good construct validity and a Cronbach's alpha of 0.91 among the local population.[20] All scores for eudaimonic well-being, stress, and general well-being were calculated by summation of responses. The questionnaire was self-administered to the respondents through an online survey platform at each data collection site.

The IBM Statistical Package for Social Science version 29 software was used to describe the frequency and percentage for categorical variables and mean and standard deviation for numerical variables. The items were analyzed for potential flooring or ceiling effects and were screened for normality using skewness, kurtosis, and Shapiro-Wilk tests. To establish construct validity, both exploratory and confirmatory factor analyses were used to analyze the final Malay QEWB. Items with a factor loading of 0.40 during the exploratory and confirmatory factor analyses were removed.[17] The exploratory factor analysis was performed using principal component analysis with Varimax rotation and an eigenvalue above 1.0 as a cut-off for identifying significant factors. Several factor structures were iterated to determine the most parsimonious solution to the Malay QEWB measurement model. The one-factor solution was also analyzed for consistency with the original questionnaire.

Missing data analysis and appropriate missing data treatment were performed using mean substitution. Confirmatory factor analysis utilized structural equation modeling on IBM's Analysis of Moment Structure (AMOS) version 27. Goodness of fit was determined using CMIN/df < 3.0, comparative fit index (CFI) > 0.90, Tucker-Lewis index (TLI) > 0.90, root mean square error of approximation (RMSEA) ≤ 0.08, and standardized root mean square residual (SRMR) ≤ 0.08.[17] The internal consistency of the Malay QEWB was analyzed using the Cronbach index, with a value above 0.60 deemed acceptable. The average variance extracted and composite reliability were calculated using values above 0.50 and 0.80 as satisfactory cut-off, respectively. To establish convergent and divergent validities, Pearson's correlation was used to determine the correlation between the Malay QEWB scores and general well-being and stress scores, respectively, with correlation indices reporting *p*-values < 0.05 being considered significant.

RESULTS

A total of 229 respondents participated in the research, reflecting a response rate of 90.9% compared to the target sample size. The sociodemographic characteristics are presented in Table 1. The respondents were predominantly female (83.4%, N = 191), of Malay ethnicity (83%, N = 190), and of Islamic religion (89.1%, N = 204). Other ethnicities, such as Chinese, Indian, and Borneo, constituted the majority of respondents. The majority of respondents' fathers either worked in the civil service (25.8%, N = 59), had no employment/retired (25.8%, N = 59), or were self-employed (28.8%, N = 66). The majority of mothers were unemployed or retired (45%, N = 103), and some worked in the civil service (32.3%, N = 74). Both parents were commonly tertiary educated, either at the undergraduate or postgraduate level, and less than 4% received no formal education. Household income was commonly less than MYR 3,000 (28.8%, N = 66), followed by MYR 3,001 to MYR 6,000 (21.4%, N = 49), more than MYR 12,000 (19.2%, N = 44), MYR 9,001 to MYR 12,000 (17.0%, N = 39), and MYR 6,001 to MYR 9,000 (10.9%, N = 25). The majority of the parents were still married (82.1%, N = 188), and others were divorced (7.4%, N = 17), deceased spouse (7.0%, N = 16), or single mother (2.2%, N = 5).

Table 2 summarizes the item analysis for the translated QEWB Malay questionnaire. The values of skewness and kurtosis were −0.95 to 1.19, which is within the normal limits. The Shapiro-Wilk index reported values between 0.80 and 0.94 across all items, which are also within normal limits. [21] Therefore, the items met the normality assumptions for the inferential analysis. Corrected item-total correlations revealed indices of 0.30 for items q03, q07, q10, q11, q12, q16, q19, and q20. Whereas items q12 and q15 reported an absolute skewness value of more than 1.0, which may indicate a flooring or ceiling effect.

The Kaiser-Meyer-Olkin index was 0.76, indicating sample adequacy, and the significance of Bartlett's test of sphericity was 0.001, indicating factor structure. During the initial exploratory factor analysis, no items were removed because they did not meet the minimum 0.40 factor loading, and a four-factor solution was revealed. Five items were cross-loaded into 2 factors. These items were allocated to the factor with the largest factor loading value. Factor 1 consisted of seven items (q01, q02, q04, q06, q09, q14, q21), Factor 2 had six items (q05, q08, q13, q15, q17, q18), Factor 3 had five items (q07, q11, q12, q16, q20), and Factor 4 had three items (q03, q10, q19). The internal consistency for each factor was 0.88, 0.85, 0.74, and 0.49, respectively.

A 3-factor iteration was performed to overcome the poor internal consistency of Factor 4. The second iteration revealed that Factor 1 retained similar items, Factor 2 had seven items (q3, q05, q08, q13, q15, q17, q18), and Factor 3 had seven items (q07, q10, q11, q12, q16, q19, q20). Self-expression intensity, importance of fulfillment, and attitude toward growth were the factors. The choice of names was based on the eudaimonic identity theory and six interrelated concepts within the theory. [18] The internal consistencies for self-expression intensity, importance of fulfillment, and attitude toward growth were 0.88, 0.78, and 0.74, respectively. The overall internal consistency was 0.78.

The 1-factor solution revealed 6 items with factor loading less than 0.40, which were removed, and 15 items were retained. The remaining items reported factor loadings ranging from 0.46 to 0.81 and an internal consistency value of 0.81. Interestingly, all the removed items were reverse-coding items, and only 2 reverse-coding items (q11 and q20) remained after the exploratory factor analysis. Table 3 summarizes the results of the exploratory factor analyses.

Before the CFA, a missing value analysis was performed, which revealed less than 1% missing data across items measuring eudaimonic well-being, stress, and general well-being. Mean substitution was used to treat missing data. The 3-Factor measurement model revealed poor goodness-of-fit indices with a CMIN/df of 2.41, CFI of 0.86, and TLI of 0.84. RMSEA = 0.08, and SRMR = 0.09.

Items q03, q07, q10, and q19 showed factor loadings of 0.40 and were removed from the measurement model. Modification indices were also consulted, revealing covariance between the error terms. The modified 3-Factor measurement model, as shown in Diagram 1, revealed improved goodness-of-fit indices with CMIN/df of 1.53, CFI of 0.97, and TLI of 0.96. RMSEA, 0.05; SRMR, 0.05.

The final questionnaire retained 17 items from the original 21 items with self-expression intensity measured by seven items (q01, q02, q04, q06, q09, q14, and q21), importance of fulfillment measured by six items (q05, q08, q13, q15, q17, and q18), and attitude toward growth measured by four items (q11, q12, q16, and q20). The 3-Factor solution reported an average variance extracted of 0.59 and a composite reliability of 0.93.

The 1-factor measurement model revealed poor goodness-of-fit indices with a CMIN/df of 3.11, CFI of 0.87, and TLI of 0.85. RMSEA = 0.10, and SRMR = 0.09. Modification indices reveal covariance between the error terms. The modified 1-factor measurement model showed improved goodness-of-fit indices with CMIN/df = 2.30, CFI = 0.92, TLI = 0.91, RMSEA = 0.07, and SRMR = 0.06. Item q20 reported a factor loading of less than 0.40 in the modified 1-Factor measurement model but was retained to preserve the reverse-coding item in the questionnaire. The 1-factor solution reported average variance extracted of 0.50 and composite reliability of 0.87.

For eudaimonic well-being, scores were computed for each factor and the overall score in the 3-Factor model and the overall score in the 1-Factor model. Each of the scores was correlated with stress and general well-being scores to establish divergent and convergent validities, respectively. Table 4 summarizes the correlation coefficients of the constructs.

Factors under the 3-Factor model of eudaimonic well-being showed weak to strong positive correlation with each other (r = 0.27–0.72, p < 0.01). The self-expression intensity factor exhibited a moderate negative correlation with stress and a strong positive correlation with general well-being. The importance of fulfillment factor showed a weak negative correlation with stress and a moderate positive correlation with general well-being. The attitude toward growth showed a moderate negative correlation with stress and a moderate positive correlation with GWB.

Finally, the total score for the 3-Factor model of eudaimonic well-being showed a weak negative correlation with stress and a moderate positive correlation with general well-being. The 1-factor model of eudaimonic well-being reported a moderate negative correlation with stress and a strong positive correlation with general well-being. The correlation direction indicated divergent and convergent validities, respectively, in both the 3-Factor and 1-Factor models.

TABLE 1. Summary of the sociodemographic characteristics of the respondents (N = 229)

Variable	N	%
Gender		
Female	191	83.4
Male	36	15.7
Ethnicity		
Borneo descendant	26	11.3
Chinese	5	2.2
Indian	2	0.9
Malay	190	83.0
Religion		
Buddhist	3	1.3
Christian	18	7.9
Hindu	1	0.4
Islam	204	89.1
Father's occupation		
Corporate staff	40	17.5
Civil service	59	25.8
No employment/Retired	59	25.8
Self-employed	66	28.8
Mother's occupation		
Corporate staff	24	10.5
Civil service	74	32.3
No employment/Retired	103	45.0
Self-employed	23	10.0
The father's highest education		
No formal education	8	3.5
Primary or secondary	86	37.6
Undergraduate	91	39.7
Postgraduate	38	16.6
The mother's highest education		
No formal education	7	3.1
Basic school certificate (primary or secondary)	92	40.2
Undergraduate	91	39.7
Postgraduate	35	15.3
Household income		
≤ MYR 3,000	66	28.8
MYR 3,001 – MYR 6,000	49	21.4
MYR 6,001 – MYR 9,000	25	10.9
MYR 9,001 – MYR 12,000	39	17.0
> MYR 12,000	44	19.2
Parent's marital status		
Deceased father/mother	16	7.0
Divorced	17	7.4
Married	188	82.1
Single	5	2.2

TABLE 2. Item analysis for the translated Malaysian Questionnaire for Eudaimonic Well-Being (QEWB)

Item Code	Mean ± SD	Corrected item-total correlation	Skewness	Kurtosis
q01	4.37 ± 1.09	0.74	−0.38	0.18
q02	4.14 ± 1.28	0.66	−0.41	−0.38
q03	4.54 ± 1.28	0.21	−0.78	0.09
q04	4.72 ± 1.05	0.62	−0.57	−0.05
q05	5.00 ± 1.07	0.50	−0.95	0.14
q06	4.62 ± 1.18	0.67	−0.79	0.32
q07	3.29 ± 1.39	0.13	0.08	−0.88
q08	4.97 ± 0.99	0.58	−0.97	1.19
q09	4.17 ± 1.32	0.68	−0.48	−0.30
q10	4.04 ± 1.36	0.19	−0.35	−0.38
q11	3.44 ± 1.50	0.19	0.05	−0.95
q12	2.30 ± 1.39	0.12	1.09	0.32
q13	5.13 ± 0.82	0.53	−0.53	−0.58
q14	4.52 ± 0.93	0.52	−0.22	−0.22
q15	5.16 ± 0.94	0.48	−1.02	0.59
q16	4.18 ± 1.45	0.19	−0.50	−0.69
q17	4.46 ± 1.07	0.60	−0.35	−0.25
q18	5.08 ± 0.84	0.52	−0.60	−0.31
q19	3.03 ± 1.41	0.08	0.41	−0.60
q20	3.63 ± 1.37	0.17	−0.13	−0.60
q21	4.08 ± 1.28	0.64	−0.29	−0.56

TABLE 3. Factors and factor loading for the Malaysian Questionnaire for Eudaimonic Well-Being (QEWB) items

Item Code	4-Factor				3-Factor			1-Factor
	1	2	3	4	1	2	3	
q01	0.77				0.77			0.81
q02	0.76				0.79			0.77
q03				0.63		0.44		R
q04	0.64				0.65			0.70
q05	0.45	0.46			0.43	0.44		0.60
q06	0.74				0.74			0.76
q07 (reverse)			0.72				0.63	R
q08	0.49	0.55			0.46	0.52		0.67
q09	0.88				0.87			0.77
q10				0.67			0.42	R
q11 (reverse)	−0.43		0.64		0.49		0.65	0.50
q12 (reverse)			0.66				0.72	R
q13		0.68				0.71		0.60
q14	0.43				0.45			0.58
q15		0.68				0.71		0.61
q16 (reverse)			0.69				0.52	R
q17	0.49	0.56			0.47	0.55		0.69
q18		0.74				0.74		0.65
q19 (reverse)			0.41	0.58			0.67	R
q20 (reverse)			0.62		0.43		0.61	0.46
q21	0.70				0.69			0.71

R–item removed due to factor loading of less than 0.40

DISCUSSION

Research in Malaysia has largely emphasized diagnosis and treatment, with a limited focus on positive psychology. As the prevalence of mental illness increases, the need to advocate for living with the illness becomes more relevant. Hence, a positive psychology perspective is needed to understand and intervene. However, the lack of validated instruments hinders research progress from the perspective of positive psychology. Therefore, this study aimed to translate and validate the questionnaire for eudaimonic well-being (QEWB) among Malaysian youth, particularly those attending higher education institutions.

There was a reduction in the number of items in both the 3- and 1-Factor models. This reduction may reflect cultural

TABLE 4. Correlation between eudaimonic well-being, stress, and general well-being

Variable	Mean ± SD	Correlation coefficient	
		Stress	General well-being
Eudaimonic well-being (Factor 1)	67.5 ± 11.01	−0.49*	0.73*
Eudaimonic Well-Being (Factor 3)	73.8 ± 8.99	−0.23*	0.56*
Self-expression intensity	30.6 ± 6.28	−0.42*	0.76*
Importance of fulfillment	29.8 ± 4.16	−0.34*	0.50*
Attitude toward growth	13.4 ± 4.25	−0.49*	0.44*
Stress	15.2 ± 7.29	-	-
General well-being	16.2 ± 4.92	-	-

* $p < 0.01$

differences in understanding the items. Most notably, the removed items were all reverse-coding items, which was an observed outcome in several previous studies that translated and validated questionnaires cross-culturally.[22,23] The lack of reverse-coding items reduces the ability to detect inconsistency of responses to the questionnaire. Therefore, the decision to retain as many reverse-coding items as possible was made.

The discovery of the 3-Factor model was novel in this study compared to the original factor structure of the QEWB questionnaire. This study proposes to name the three factors as follows: (a) self-expression intensity, (b) importance of fulfillment, and (c) attitude toward growth. This difference in factor structure may have been contributed by the cultural interpretation of eudaimonic well-being. Asian cultures tend to be collectivist.[24] and may view self-expression, fulfillment, and attitude within the context of their relationships with others. Thus, factor splitting may occur compared with the more individualistic nature of Western culture.[25]

The self-expression intensity factor described how individuals linked their understanding of self toward action. This necessitates a clear description and deep belief in oneself, and projecting that into an individual's life as their purpose.[26] A sense of purpose is crucial for mental well-being, even during times of extreme challenge, such as the COVID-19 pandemic.[27] College students coped better with stress and anxiety during the COVID-19 pandemic due to a strong sense of purpose.

The importance of the fulfillment factor describes the positive experience and perception of an action that is applicable during both easy and challenging times. This concept is more enduring than the fleeting experience of happiness or excitement. A previous study reported that positive psychological attributes, such as mindfulness, grit, and adaptability, predicted higher emotional stability and lower academic burnout among the undergraduate population in Pakistan.[28] The interpretation of challenging experiences may also impact the physical and psychological states differently, depending on the individuals' perception and beliefs. Interventions that integrate positive perception have been shown to reduce insomnia and trait anxiety.[29] as well as improve resilience, prosocial behavior, and mental well-being across different populations and settings.[29–31]

Finally, the attitude toward growth factors described the degree of willingness to put effort into one's development. Developing oneself often involves growth pains accompanied by stress, lethargy, disappointment, and failure.[32] Once an individual has committed to developing a specific aspect of themselves, they will undertake actions that either reduce the negative elements or increase the positive elements contributing to the specific aspect of themselves. This has been applied in the field of behavioral modification that targets behavior deficits or behavior excesses in an individual or community.[33] Youth who experienced trauma during their childhood years developed better mental well-being upon self-reliance and commitment to managing their mental health.[34] Youth take responsibility for themselves and may adopt specific coping skills to manage their mental health.

There are several strengths to this study. First, the quota sampling ensures that youth from different regions are represented in the validity and reliability of the questionnaire. Second, the discovery of the 3-Factor model enables future researchers to explore the predictors toward specific factors of eudaimonic well-being. Practitioners can identify specific elements of eudaimonic well-being that is lacking and tailor an intervention to that element. Third, the validity and reliability of the 1-Factor model enable cross-cultural comparison of eudaimonic well-being. Local researchers or practitioners who prefer to use a shorter version of eudaimonic well-being may choose the 1-Factor model. Finally, the convergent and divergent validity were determined using questionnaires used in Malaysia for at least 5 years. This provides a reliable benchmark for establishing the validity of the questionnaire.

Several limitations were noted and may be improved in future research. First, the respondents involved in this study were predominantly female and of Malay ethnicity at a proportion higher than the population proportion. Therefore, the validity results are biased toward these sociodemographic characteristics. Future researchers should consider assessing the construct validity and internal consistency of the Malay QEWB among their

respondents, especially those of non-Malay ethnicity and male sex.

Second, the spectrum of stress scores was wide, indicating that the Malay QEWB is applicable regardless of mental health status. However, the presence of mental illness and how it would impact the Malay QEWB score were not explored. Future researchers should expand the understanding of eudaimonic well-being and how the Malay QEWB score differs between individuals with and without mental illness. Such understanding would inform the feasibility of using eudaimonic well-being as an outcome measure of treatment progress for patients with mental illness.

Third, more research should be conducted to understand the predictors of eudaimonic well-being among the Malaysian population, especially adolescents and youths. Understanding the eudaimonic well-being of adolescents and youth enables the integration of the concept into their developmental activities in either academic institutions or family development. A developmental psychologist may provide input on how to integrate eudaimonic well-being into the curriculum of the Ministry of Education Malaysia or the National Population and Family Development Board (Malay acronym: LPPKN) courses.

CONCLUSIONS

The Malay QEWB questionnaire showed good construct, convergent and divergent validity and internal consistency among youth in Malaysia, albeit with a lower number of items. The availability of the questionnaire measuring eudaimonic well-being should enable the exploration of mental health through the perspective of positive psychology. Local research will contribute to the evidence base of global research advances and enable cross-cultural understanding of the construct. Emphasis of research and intervention on productive living and the functional aspects of mental illness is now possible.

CONFLICTS OF INTEREST

None declared.

FUNDING

None declared.

Received: November 5, 2025 | Accepted: March 2, 2026

REFERENCES

1. World Health Organization. *World mental health today: the latest data*. Geneva: World Health Organization, 2025.
2. Kamaruddin MSB, Yahya F, Sabil S, Ma'rof AA, Harun MM, Md Salim J. Mental health issues in Malaysia: A systematic review. *Afr J Soc Work*. 2022;12:295–305.
3. Institute for Youth Research Malaysia, UNICEF. *The Malaysian Youth Mental Health Index, 2023*. Putrajaya: Institute for Youth Research Malaysia & United Nations Children's Fund, 2024.
4. Ryan RM, Deci EL. Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *Am Psychol*. 2000;55:68–78.
5. Beyrer C, Shisana O, Baral SD, Milsana K, Mayer KH, Pozniak A, *et al*. The science of Durban, AIDS 2016. *J Int AIDS Soc*. 2017;20:21781.
6. Karaca G, Tanova C, Gokmenoglu K. How do shared values improve eudaimonic workplace well-being: role of perceived justice and emotional exhaustion among nurses. *J Health Organ Manag*. 2023;37:158–76.
7. Cheah YK, Azahadi M, Phang SN, Abd Manaf NH. Sociodemographic, lifestyle, and health factors associated with depression and generalized anxiety disorder among Malaysian adults. *J Prim Care Community Health*. 2020;11:2150132720921738.
8. Shukri M, Armitage CJ, Koon CS, Tarmizi NN. Stressors and suicidal ideation in low-income adults in Malaysia: A serial mediation analysis of social support and mental health symptoms. *Int J Soc Psychiatry*. 2025;71:295–306.
9. Mohd Tamil A, Ismail NH, Jaafar MH, Md Isa Z, Ismail R, Mat Nasir N, *et al*. Depressive symptoms among adults: Baseline findings of PURE Malaysia cohort study. *Heliyon*. 2023;10:e23042.
10. Wang J, Pang M, Jiang X, Li H, Xu J, Liu G, *et al*. The chain mediation model of social support and life satisfaction among migrant older adults with children: The role of mental health and sleep quality. *Arch Gerontol Geriatr*. 2023;115:105122.
11. Silim UA, Suhaimi AF, Moore G, Ryan B, Castle DJ. Beyond psychiatry: motivations for considering an Australian wellbeing program within Malaysian health services. *Australas Psychiatry*. 2019;27:262–6.
12. Gopinathan S, Kaur AH, Ming LM, Alias MB, Veeraya S. Awareness of behavioral intervention strategies in curing mental health issues among youth in Malaysia. *Int J Environ Res Public Health*. 2022;19:15376.
13. Bogert A, Lu JJ. I will always be a mother. Now, I am an advocate. *J Subst Use Addict Treat*. 2025;175: 209724.
14. Chan KKS, Tsui JKC. Longitudinal impact of stigma resistance on mental health among individuals with mental disorders. *Qual Life Res*. 2025;34:2061–72.
15. Liem A, Chih HJ, Velaithan V, Norman R, Reidpath D, Su TT. A comparison of health-related quality of life using the World Health Organization Quality of Life-BREF and 5-Level EuroQol-5 Dimensions in the Malaysian population. *Osong Public Health Res Perspect*. 2025;16:126–40.
16. Rahman A, Iqbal Z, Waheed W, Hussain N. Translation and cultural adaptation of health questionnaires. *J Pak Med Assoc*. 2003;53:142–7.
17. Kyriazos TA. Applied psychometrics: sample size and sample power considerations in factor analysis (EFA, CFA) and SEM in general. *Psychology*. 2018;9:2207–30.

18. Waterman AS, Schwartz SJ, Zamboanga BL, Ravert RD, Williams MK, Agocha VB, *et al*. The questionnaire for eudaimonic well-being: psychometric properties, demographic comparisons, and evidence of validity. *J Posit Psychol*. 2010;5:41–61.
19. Musa R, Fadzil MA, Zain Z. Translation, validation and psychometric properties of Bahasa Malaysia version of the Depression Anxiety and Stress Scales (DASS). *ASEAN J Psychiatr*. 2007;8:82–9.
20. Suhaimi AF, Makki SM, Tan KA, Silim UA, Ibrahim N. Translation and validation of the Malay version of the WHO-5 well-being index: Reliability and validity evidence from a sample of type 2 diabetes mellitus patients. *Int J Environ Res Public Health*. 2022;19:4415.
21. Mohd Razali N, Wah YB. Power comparisons of shapiro-wilk, kolmogorov-smirnov, lilliefors and anderson-darling tests. *J Stat Model Anal*. 2011;2:21–33.
22. Venta A, Bailey CA, Walker J, Mercado A, Colunga-Rodriguez C, Ángel-González M, *et al*. Reverse-coded items do not work in Spanish: Data from four samples using established measures. *Front Psychol*. 2022;13:828037.
23. Mellinger CD, Hanson TA. Psychometric properties of survey translations: A simulation study. *Transl Cogn Behav*. 2024;7:159–85.
24. Chua SY, Himawan K. The exploration of attitudes and perspectives of mental health workers on peer support in Singapore. *Discov Ment Health*. 2025;5:1.
25. Hughes C. The influence of self-concept, parenting style and individualism-collectivism on career maturity in Australia and Thailand. *Int J Educ Vocat Gui*. 2011;11:197–210.
26. Dooris M, Farrier A, Froggett L. Wellbeing: the challenge of 'operationalizing' an holistic concept within a reductionist public health program. *Perspect Public Health*. 2018;138:93–9.
27. VanRoo C, Norvilitis JM, Reid HM, O'Quin K. The new normal: amotivation, sense of purpose, and associated factors among college students during the COVID-19 pandemic. *Psychol Rep*. 2025;128:2336–52.
28. Sarwer S, Abid MN, Chao H, Siming L, Dukhaykh S. Examining the impact of positive psychological attributes on emotional stability and academic burnout among undergraduate students: a cross-sectional study. *BMC Psychol*. 2025;13:614.
29. Ng TY, Ng TK, Siu OL. Enhancing mental well-being in university students through multicomponent low intensity positive education and the mediating role of civic engagement. *Sci Rep*. 2025;15:20871.
30. Naeem NiK, Mushibwe CP. Navigating digital worlds: a scoping review of skills and strategies for enhancing digital resilience among higher education students on social media platforms. *Discov Educ*. 2025;4:39.
31. Abd Razak MA, Silim UA, Suhaimi AF, Ramly SS, Ismail NN, Mohd Salleh A, Mohamad AW. An intervention to determine the effectiveness of the Sanubari optimal health program (OHP) in improving mental well-being among junior doctors in Malaysia: a quasi-experimental study. *BMC Public Health*. 2024;24:2621.
32. St Clair-Thompson H, London J. Does mental toughness predict happiness over and above resilience, self-efficacy and grit? *New Ideas Psychol*. 2024;74:101093.
33. Powers MD, Palmieri MJ, D'Eramo KS, Powers KM. Behavioral Intervention echniques for Reducing Problem Behavior. In Reichow B, Doehring P, Volkmar FR. (eds.), Handbook of Evidence-Based Practices in Autism Spectrum Disorder. Cham: Springer: 2025. p.251–88.
34. Lynch L, Moorhead A, Long M, Steele IH. "I Felt Like There Was Something Wrong in My Brain": Growing Up with Trauma - How Young People Conceptualise, Self-Manage and Seek Help for Mental Health Problems. *J Child Adolesc Trauma*. 2024;18:103–25.